

Issue Memo: Proposal To Establish the Evaluation Coordination Work Group

The purpose of this issue memo is to establish the Evaluation Coordination Work Group comprised of the Department of Mental Health, the California Mental Health Planning Council, and the Mental Health Services Oversight and Accountability Commission. It identifies the problems in the Mental Health Services Act (MHSA) related to overlapping responsibilities for performance outcome and accountability. It also highlights tools that are under development to provide a framework to analyze the unique tasks required to develop a unified system of performance measurement and accountability for the MHSA and the public mental health system as a whole. Using these tools, the Evaluation Coordination Work Group can develop recommendations advisory in nature to resolve the duplication presently inherent in the statutory scheme. With these tools, the work group can also ensure that the quality improvement and accountability needed to transform the mental health system is also achieved. In this issue memo, the term “individuals” will be used to refer to children and youth with serious emotional disturbances; adult and older adult consumers; or persons receiving services from components of the MHSA, such as Prevention and Early Intervention and Innovative Programs. The term “family” will be used to refer to parents and other caregivers of persons receiving services.

Background

In November 2004, Californians passed the MHSA. The Act defines the roles and responsibilities of three state-level groups: the Department of Mental Health (DMH), the California Mental Health Planning Council (CMHPC), and the Mental Health Services Oversight and Accountability Commission (MHSOAC). Each organization has statutory responsibility to ensure accountability for the quality and outcomes of mental health programs funded by the MHSA.

The MHSA requires that California evolve and transform the entire public mental health system as follows (Section 3, page 2 of the MHSA):

- (a) Define serious mental illness among children, adults and seniors as deserving priority attention
- (b) Reduce the long-term adverse impact resulting from untreated serious mental illness
- (c) Expand successful innovative services programs, including culturally and linguistically competent approaches for underserved populations
- (d) Provide state and local funds to adequately meet the needs of identified individuals in programs funded under the MHSA
- (e) Ensure that all funds are expended in the most cost effective manner and that they are subject to oversight to ensure accountability to taxpayers and to the public

Having a unified system of study, measurement, and outcomes is critical to promoting accountability and quality improvement of programs funded by the MHSA and of the entire public mental health system. This system must meet the mandates and needs of the three governmental entities and avoid all duplication of efforts. However, statutory duties overlap significantly. The DMH, CMHPC, and MHSOAC each have specific statutory responsibilities for outcomes, measurement, and quality improvement. For example, Section 5846(a) of the Welfare and Institutions Code (WIC) states “The Commission shall annually review and approve each county mental health program for expenditures pursuant to Part 3.2 (commencing with Section 5830), for innovative programs and Part 3.6 (commencing with Section 5840), for prevention and early intervention.” Additionally, WIC Section 5848(c) “states the department (DMH) shall establish requirements for the content of the plans. The plans shall include reports on the achievement of performance outcomes for services pursuant to Parts 3, 3.6, and 4 funded by the Mental Health Services Fund and established by the department.” Furthermore, WIC Section 5848(d) states “mental health services provided pursuant to Parts 3 and 4 shall be included in the review of program performance by CMHPC required by WIC Section 5772(c)(2) and in the local mental health board’s review and comment on the performance outcome data required by WIC Section 5604.2(a)(7). The sections devoted to the DMH, CMHPC, and MHSOAC also describe goals of the system for diversity, cultural competency, and equal opportunity to receive care that is appropriate for the individual.

In addition to duplication and overlap of statutory responsibilities regarding outcomes and accountability, duplication exists in reporting and paperwork requirements imposed on county mental health departments and community-based agencies. For example, these entities must collect data every time an individual receives mental health services. If an individual is receiving services from the MHSA in a Full Service Partnership, additional encounter-level data must be collected. Twice a year Consumer Perception of Care Surveys are required to be collected on most individuals receiving services during a two-week period. County mental health departments and community-based agencies are also subject to a variety of time-consuming on-site reviews, such as Medi-Cal managed care on-site reviews, external quality review organization reviews, Early Periodic Screening Diagnosis and Treatment documentation reviews, Licensing and Certification reviews, and Substance Abuse and Mental Health Services Administration Block Grant reviews. In addition, on-site reviews for AB 3632 and the Mental Health Services Act are also scheduled to begin. Preparing for these reviews requires staff time assembling the necessary records and participating in interviews. In some instances, consumers and families are asked to give their time for focus groups.

The DMH is developing a framework that can be used to provide clarity and focus for the system for developing outcomes and accountability for the MHSA and the public mental health system. For the MHSA, the DMH has proposed an

Accountability Framework. This framework is in draft and under review. It consists of accountability principles, an overall logic model, evaluation questions, and evaluation system components. The evaluation questions and evaluation system components form a matrix so that each question is answered by one or more evaluation components. This framework is intended to operate so that appropriate evaluation questions and components can be applied to each element of the MHSA: Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Education and Training, Capital Facilities and Information Technology, and Innovation. Each component will be further elaborated with its own evaluation questions that will fit into the overall framework.

Referenced in this framework is the tri-level paradigm for performance measurement developed by the DMH when evaluation and accountability discussions began for MHSA. This paradigm posits that performance measurement operates at three levels: the individual level, the mental health system accountability level, and the public/community-impact level. At the individual level, demographic information and services are tracked as are individual outcomes. The system accountability level entails program monitoring and quality assurance functions, individual and family satisfaction measurement, and evaluation of services and supports. The community level involves measuring effects of community-focused strategies. These strategies could include mental health promotion efforts, such as anti-stigma campaigns. Measurement at this level would include large-scale community indicators, such as rate of homelessness, rate of suicide, and prevalence of mental illness.

Goals

On January 24, 2007, representatives from the DMH, CMHPC, and MHSAOC (hereafter referred to as government partners) met to discuss their joint responsibilities for measurement of program quality and outcomes in the public mental health system. Each organization identified challenges regarding potential duplication of effort due to lack of coordination among the three entities in performance measurement and accountability. In order to increase coordination and decrease the likelihood of duplication of requirements to providers (counties and community-based agencies), representatives from the government partners proposed forming a single committee that would be responsible for overseeing performance measurement and assessing the outcomes of California's publicly funded mental health programs.

On April 25, 2007, representatives from the government partners, county mental health departments, and community-based agencies reconvened to further develop the proposal. The group achieved consensus on five goals:

1. To use MHSA funding to transform the entire public mental health system
2. To achieve integration of performance measurement for the MHSA with performance measurement for the entire public mental health system

3. To measure outcomes, to promote quality improvement, and to communicate the results to the multiple audiences to which the public mental health system is accountable
4. To decrease duplication and overlap among the DMH, the CMHPC, and the MHSOAC in performance measurement and accountability
5. To simplify reporting requirements for county mental health departments and community-based agencies

Proposal

The DMH, CMHPC, and MHSOAC are proposing an Evaluation Coordination Work Group to accomplish the goals that they share in addressing the problem of duplication of responsibilities for outcomes and accountability. They have chosen a “Meet and Recommend model” as the operating approach for this work group. The work group would have only advisory authority. The government partners would retain their statutory authority and independence in decision-making. The work group must reach consensus before making recommendations back to their organizations. The work group will not be performing detailed tasks, such as developing performance outcome measures. Rather, it would be responsible for recommending assignment of tasks and responsibilities to government partners and other groups.

Responsibilities

The work group would start with the following roles and responsibilities:

1. Beginning with the Accountability Framework and the tri-level paradigm, determine what tasks are already being performed and how best to coordinate those tasks among government partners and other groups and how to ensure collaboration
2. Identify duplication of effort among government partners and make recommendations to minimize it
3. Determine what gaps exist in the work needed to assure quality improvement and accountability of the MHSA and the public mental health system and make recommendations for how to ensure that necessary tasks are performed by the appropriate government partner or other group.
4. Work to reduce paperwork and simplify reporting requirements imposed on county mental health departments and community-based agencies so that more time can be spent with individuals and families.

The overarching responsibility of the work group would be to use the MHSA Accountability Framework and the tri-level paradigm to analyze outcomes and accountability tasks that are already being performed by the government partners and other entities and to identify gaps where necessary work is not being performed. In the case of work already being performed by government partners, the work group would assume the task of coordinating that work to

ensure collaboration and minimize duplication of effort. For example, one component of the Accountability Framework will result in collecting data for CSS, PEI, and Innovation on number of individuals served by ethnicity and age and on what units of services are being provided. These data can be used by the MHSOAC for its project to have baseline data to assist in evaluation of CSS Three-Year Expenditure Plans. These data can also be used by the CMHPC in its work with MHB/Cs to assist them in interpreting their local data. Analysis of the Accountability Framework would lead to this conclusion and other useful insights.

For the public mental health system as a whole, the tri-level paradigm would be useful for analyzing what work is being done and where gaps exist. Examples at each level would be helpful to illustrate this concept. First, at the individual level, the DMH is already collecting extensive data on tracking services and outcomes for the public mental health system. Second, the CMHPC and the State Quality Improvement Council (SQIC) already focus their work at the mental health system accountability level. The SQIC is a group comprised of representatives of the CMHPC, providers, quality improvement experts, and individuals and family members. This group analyzes performance indicator data and advises the DMH on performance of the mental health system and ways to achieve continuous quality improvement. One of the gaps in the system is at the third level, the community impact level, which is new to the performance measurement paradigm. In some cases, work has not yet been done to develop performance indicators. Where performance indicators have been established, methods of measurement have not been determined. The Evaluation Coordination Work Group could develop recommendations about which government partner or other group is best suited to perform these tasks. Government partners could also recommend what tasks they could perform based on their strengths and statutory responsibilities.

The work group would need to be conversant with the work of other groups in addition to the SQIC, such as the Performance Measurement Advisory Committee, which is comprised of individuals, family members, and performance measurement experts. It was created to advise the DMH on technical measurement issues. To date, it has been responsible for developing the performance indicators for the MHSA Full Services Partnerships. The government partners working group may make recommendations to groups such as these as well.

Since none of the government partners are surrendering or subordinating their statutory authority, nothing in this proposal prohibits or suggests limits on each government partner's ability to initiate accountability activities. It does propose that those activities are viewed within a total framework for accountability, that the government partners are cognizant of the five goals identified above, and that as much as possible they work to achieve those goals.

Membership

The DMH Director, the CMHPC, and the MHSOAC would each name a maximum of three persons to the Evaluation Coordination Work Group. Four other organizations are recommended to be involved in the process as ex officio members: the California Mental Health Directors Association (CMHDA), the California Council of Community Mental Health Agencies (CCCMHA), the California Association of Psychosocial Rehabilitation Agencies (CASRA), and the California Alliance of Children and Family Services (CACFS). The counties as represented by CMHDA are responsible for implementation of all community-based programs at the local level. Counties and community-based agencies are at risk for both successful implementation of measurement systems as well as for actual results. Without their input and cooperation, the State's measurement systems will not provide good information for quality improvement and transformation of mental health programs. The CCCMHA, CASRA, and CACFS represent the vast majority of community-based agencies that provide direct services through contracts with the counties. They also need to be involved since they provide a very significant amount of direct services. The CMHDA would have two representatives, and CCCMHA, CASRA, and CACFS would each have one representative, appointed by their respective boards. Consultants providing the perspective of individuals, family members, and family of youth would be needed as would expertise on cultural competence and diverse communities. Each component of the MHSA may require additional consultants with subject-matter expertise.

Process

The work group will meet on as needed basis with the expectation that the meeting schedule will be more frequent during the early stage of the group's work. To facilitate the meeting process and minimize travel to day-long meetings, the feasibility of video conferencing will be explored. In addition, conference calls will be employed. The level of support needed for this work group will be intensive, especially in the early stage of the process until the outcomes and accountability process can be developed for all components of the MHSA and eventually for the Integrated Plan. Ultimately, the MHSA process must also be integrated into the outcomes and accountability process for the public mental health system.

A consultant will be needed to provide staff support for this process. In addition, a lead staff person from each government partner will be appointed as a liaison with the consultant for this project.

Next Steps

The following process will be used to review and approve this proposal:

1. Ann Arneill-Py will complete the first draft by May 9
2. Carol Hood, Ann Arneill-Py, Beverly Abbott, Jennifer Clancy, Dan Souza, and Rusty Selix will review the first draft by May 23.
3. The DMH will arrange a conference call to discuss the draft. This process will be completed by June 8
4. The completed proposal will be provided for review and decision to the Director of the Department of Mental Health, the CMHPC, and MHSOAC.
5. If the proposal is approved, then the amount of resources needed and the source of funds will be determined. A consultant will be sought. Lead staff from each organization to serve as liaison to the consultant will be determined.